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VENEREAL DISEASES IN ENGLAND AND WALES*

EXTRACT FROM THE ANNUAL REPORT OF THE CHIEF MEDICAL OFFICER FOR THE YEAR 1961

VENEREAL DISEASES

During 1961 the trend of incidence of the venereal disease reported from the clinics maintained the pattern of recent years with considerable increases in the numbers of cases of the prevailing infections.

Syphilis

Each year since 1958 the reported number of cases of infectious syphilis has risen and the year 1961 was no exception. There have been variations in different parts of the country but, although the total is still small by the standards of some other countries, the proportionate increase is considerable. In 1960 the number of these cases was 994, of which 819 were in males and 175 in females. In 1961 there were 965 cases in males and 234 in females, a total of 1,199. Table I gives the numbers of cases of infectious syphilis reported from ten urban areas in 1960 and 1961.

TABLE I

EARLY SYPHILIS INFECTIONS DEALT WITH FOR FIRST TIME IN 1960 AND 1961 IN TEN SAMPLE AREAS

Urban Areas	1960			1961		
	Males	Females	Total	Males	Females	Total
London Administrative Area (3,179,980) ..	463	78	541	545	121	666
Merseyside (Liverpool, Bootle, Birkenhead, and Wallasey) (970,240)	74	1	75	50	1	51
Manchester and Salford (815,210)	12	6	18	22	3	25
Tyneside (Newcastle, South Shields, and Tynemouth) (446,660)	10	3	13	17	9	26
Hull — Kingston upon (300,790)	7	3	10	7	2	9
Southampton (204,000)	11	0	11	13	1	14
Bristol (436,000) ..	26	7	33	12	—	12
Birmingham (1,110,290)	15	6	21	10	9	19
Leeds and Bradford (805,860)	3	3	6	5	—	5
Sheffield (494,650) ..	4	1	5	3	—	3

Note.—Figures in brackets denote estimated populations at June 30, 1961.

*Part II of The Report of the Ministry of Health for the year ended December 31, 1961. Cmnd. 1856, p. 58. Appendix C, p. 233. H.M.S.O., London.

In 1961, as in 1960, the main increase occurred in the London area, where the number of cases in males increased from 463 to 545, an increase of 17·7 per cent., and in females from 78 to 121, an increase of 55 per cent. Apart from London there were increases in males in Manchester and Salford, on Tyneside, and in Southampton, Leeds, and Bradford. The number of cases in males decreased on Merseyside, and in Bristol, Birmingham, and Sheffield. The figure for Hull was unchanged. There was a small increase in women on Tyneside and in Birmingham, but elsewhere the numbers decreased or were not appreciably different. The ratio of men to women is greater in cases of infectious syphilis than in cases of gonorrhoea, and this is probably related to the fact that a considerable proportion of cases of infectious syphilis has been found among male homosexuals and also among merchant seamen who have contracted the disease abroad and present for diagnosis and treatment on reaching a home port. The Adviser in Venereology to the Manchester Regional Hospital Board has reported that of forty men attending with infectious syphilis in the Manchester area during 1961, nine (22·5 per cent.) had been infected by homosexual contact and no less than twenty (50 per cent.) had contracted the infection while abroad. In London, where the increase of these cases in the female was considerable, the proportion of cases among male homosexuals was still high.

Table II shows the numbers of men attending with infectious syphilis at five clinics in London during 1961 who admitted to recent homosexual contact and were presumed to have contracted the disease as the result.

TABLE II

MALES. EARLY SYPHILIS ACQUIRED BY HOMOSEXUAL CONTACT, 1961

Centre	Total Cases	Homo-sexuals	Percentage
St. Mary's Hospital ..	113	81	72
St. Peter and St. Paul's Hospital	46	30	65
St. Bartholomew's Hospital	24	15	62·5
St. Thomas' Hospital ..	61	32	52
London Hospital ..	35	5	14

The fact that the number from the East End of London, in which the London Hospital is situated, is smaller than from the West End does not necessarily mean that homosexual practices are less common in the East End. Practising homosexuals tend to seek each other's company and their meeting places are believed to be mainly in the West End. It may be that they also seek medical advice in the West End, where their friends have attended on earlier occasions.

The rise in the incidence of infectious syphilis has been consistent in the past 3 years and, in the light of the increase in other infections and of experience in other countries, it must now be regarded as significant. It is surprising that the absolute numbers are still so small, but this may be due in part to suppression of infection, or the signs of infection, as the result of widespread use of antibiotics for other conditions.

The number of new patients with late syphilis has shown an appreciable rise which is unexpected because the prevalence of these conditions is directly related to that of infectious syphilis in earlier years and because more of these cases of cardiovascular syphilis have, however, fallen in both sexes; those of neurosyphilis have risen only in males. The main increase has been in "other cases of late syphilis", including cases of latent infection in which the differential diagnosis from yaws in immigrants raises difficulties. The present rise in cases of infectious syphilis makes it likely that the number of cases of late syphilis will again increase in years to come, because the number of undiagnosed cases of infectious syphilis always rises *pari passu* with those which are recognized and treated. Details regarding late syphilis are shown in Table III.

TABLE III

LATE SYPHILIS, 1960 AND 1961

Late Syphilis	Year	Males	Females	Total
Cardiovascular Syphilis ..	1960	204	79	283
	1961	183	52	235
Neurosyphilis	1960	252	139	391
	1961	286	134	420
All Other Late or Latent Stages	1960	1,011	878	1,889
	1961	1,178	1,070	2,248
Total Late or Latent Syphilis..	1960	1,467	1,096	2,563
	1961	1,647	1,256	2,903

The difficulty of distinguishing between late latent syphilis and yaws contracted in childhood by immigrants from countries where yaws is endemic, makes the figures for these two conditions somewhat speculative. The number of cases of yaws reported from the clinics in 1961 was 579 as compared with 405 in 1960. It should be understood that all, or almost all, of these cases are of old standing and are non-infectious. Infectious yaws are still practically unknown in this country and, in any case, it is a disease which would be unlikely to flourish in our climate and in our social circumstances.

The Registrar General's figures for 1961 show a further decline in deaths from general paralysis of the insane in males and females, and a small decline in those due to tabes dorsalis in males. Deaths due to syphilitic aortic aneurysm, which rose in 1960, fell in 1961 to a lower level than in any preceding year excepting 1953–54. Deaths from tabes dorsalis and aortic aneurysm in women rose slightly (Appendix Table E). In the report for 1960, reference was made to publications by two physicians in charge of observation wards suggesting that the number of cases of general paralysis might be increasing. This suggestion receives no support from a recent survey by the Adviser in Venereology to the Manchester Regional Hospital Board. In the period 1951 to 1960 there were 700 cases of general paralysis in five major mental hospitals, ten psychiatric units in general hospitals, four neurological units, and twenty clinics for venereal disease in the area of the Manchester Regional Hospital Board. Of these, 371 were diagnosed in the years 1951 to 155 and 329 during 1956 to 1960. The number of cases in 1960 was 51, fewer than in any previous year of the decade.

In 1961 the number of new cases of congenital syphilis in infants in the first year of life was 23, as compared with eighteen in 1960. The death rate of infants under one year of age certified in returns to the Registrar General as due to congenital syphilis was nil, as in 1960. The fact that the incidence of early congenital syphilis remains so low, in spite of some increase in infectious syphilis in adults is a tribute to the vigilance which is exercised at antenatal clinics throughout the country. These cases may be reduced still further when all practitioners come to regard routine serological tests for syphilis as an essential part of antenatal care. The number of cases of late congenital syphilis reported from the clinics (Appendix Table C) shows a satisfactory decline from 371 in 1960 to 317 in 1961. Some of these cases are a legacy from years in which infectious syphilis was more common in the population than it is at the present time.

Testing for Syphilis in Pregnancy.—Results of serological tests for syphilis in pregnant women, from six regional blood transfusion centres where

these routine tests are done for the regions concerned, are shown in Table IV.

A summary of results of tests on sera of primiparae and multiparae at these centres during the past seven years is given in Table V, which shows that the percentage incidence of positive tests, after a period of decline in preceding years, rose in 1961. The numbers are still very small indeed and it is impossible to say whether this rise is significant. A contributory factor may be an increase in the number of women immigrants from the West Indies. Positive serological tests are considerably more common in these women than in the indigenous population, although hardly any of them have signs of active disease and the distinction between late syphilis and old yaws is impossible in most cases.

TABLE V

Year	Primiparae		Multiparae	
	No.	Percentage Positive	No.	Percentage Positive
1953	28,263	0·21	27,573	0·43
1954	39,181	0·23	47,941	0·32
1955	41,392	0·21	40,712	0·43
1956	48,420	0·28	40,295	0·35
1957	49,914	0·14	43,730	0·29
1958	49,315	0·13	40,765	0·23
1959	56,962	0·14	46,531	0·16
1960	61,606	0·08	46,349	0·14
1961	67,294	0·13	49,583	0·27

Gonorrhoea

The number of new cases diagnosed at the clinics has again risen, from 33,770 in 1960 to 37,107 in 1961, an increase of 10 per cent. as compared with a rise of 8 per cent. in 1960 over 1959.

During the last 20 years this figure has only been exceeded in 1946 when the total was 47,343. Again multiple infections have played their part in increasing this total. Patients who contract gonorrhoea more than once in the course of a year and who seek advice at a clinic on each occasion, appear in the returns as a separate case on each occasion. Table VI indicates the extent to which this factor affected the figures for 1961 at seven large clinics—four in London and three in the provinces.

TABLE VI

GONORRHOEA, 1961, IN SEVEN LARGE CITY CLINICS

Clinics	Cases		Patients	
	Males	Females	Males	Females
The London Hospital ..	1,907	449	1,485	375
St. Mary's Hospital, London..	3,172	754	2,847	662
St. Peter and St. Paul's Hospital, London	1,436	174	1,126	157
St. Thomas' Hospital, London	1,127	314	1,083	287
General Hospital, Birmingham	1,827	469	1,511	412
St. Luke's Clinic, Manchester	1,486	444	1,165	388
General Hospital, Newcastle-on-Tyne	344	123	318	112

The reasons for the increase in gonorrhoea were discussed in the Reports for 1959 and 1960. Immigration from Commonwealth countries has continued and the numbers have increased. This movement of population, and the conditions under which some of these immigrants live, inevitably give rise to circumstances leading to spread of venereal disease. In spite of suggestions to the contrary, the experience at the venereal disease clinics has been that the majority of infections with which these immigrants present have been contracted in this country; those who arrive with infectious disease seem to be few in number. Examination of the facts at one large clinic in London, covering the period October 1, 1960, to March 31, 1961, showed that, of 368 male immigrants suffering from gonorrhoea who were attending a clinic for the first time after arriving in this country, only fifteen had acquired the disease before arrival, and some of these had been infected in foreign countries during the period of transit. Nevertheless, the contribution which immigrants and others from

TABLE IV

SYPHILIS TESTS IN PREGNANCY, 1961

Regional Blood Transfusion Centre	No. of Ante-natal Patients Tested			Positive Syphilis Tests				
	Primiparae	Multiparae	Parity not known	Primiparae		Multiparae		Parity not known
				No.	Per cent.	No.	Per cent.	No.
Cambridge	8,601	3,381	693	6	0·07	3	0·09	1
Leeds	10,677	9,748	2,877	17	0·16	27	0·27	6
Liverpool	24,479	22,065	—	35	1·14	70	0·31	—
Oxford	3,646	3,403	298	3	0·08	6	0·17	—
Plymouth	2,078	1,992	—	10	0·05	5	0·24	—
Sheffield	17,813	8,994	—	18	0·10	24	0·26	—

In addition 35 doubtful results were reported in Primiparae and 34 in Multiparae.

abroad make to the problem of gonorrhoea is very considerable. A recent investigation by the British Cooperative Clinical Group of the Medical Society for the Study of Venereal Diseases of the racial distribution of cases of gonorrhoea in the year 1960 was based on information obtained from 150 clinics in England and Wales. Of 21,663 cases in males, 25·5 per cent. were in West Indian men, 25 per cent. in others from abroad, and 49·5 per cent. were drawn from the indigenous population. Of 5,912 cases in women, 7·9 per cent. were in West Indians, 9·1 per cent. in others from abroad, and 83 per cent. in women from this country.

Much infection among male immigrants is contracted from prostitutes among whom the incidence of infection is high. Nevertheless the Consultant Venereologist at H.M. Prison, Holloway, reports that less gonorrhoea was found among prostitutes in 1961 than in the preceding year; yet the number of admissions to the prison increased from 859 in 1960 to 899 in 1961, and of these, 528 in 1960 and 537 in 1961 were known to be prostitutes. In 1961, 173 (32 per cent.) of the prostitutes were in the age group 15 to 20 years, and 157 (30 per cent.) were 21 to 25 years old. Of 476 prostitutes who submitted to examination, 112 (23 per cent.) were suffering from gonorrhoea. Some were found to be infected on more than one occasion, the total number of gonococcal infections in this group being 130. Of the 173 girls aged 15 to 20, 162 were examined, 51 (31 per cent.) were suffering from gonorrhoea, and in the course of the year, ten were found to be infected on two occasions. The incidence of gonorrhoea in prostitutes aged 20 and under, however, declined from 46 per cent. in 1960 to 31 per cent. in 1961. The consultant venereologist doubted whether these figures presented a true picture of the problem. Uncertainty arises from the fact that gonorrhoea is often difficult to diagnose in women and some of the women were not under observation long enough to ensure that the possibility of infection was excluded.

Evidence from the clinics suggests that there is still a disproportionate increase in gonorrhoeal infection among adolescents. The British Cooperative Clinical Group also investigated the incidence of gonorrhoea in young persons aged 15 to 19 years during the year 1960. Information obtained from the same 150 clinics in England and Wales indicated that in 1960, 6·4 per cent. of males and 26·3 per cent. of females attending with gonorrhoea were between the ages of 15 and 19 years. A comparison with earlier studies shows a significant increase in infection among young persons since 1957. Between 1957 and 1960 the increase in males aged 15 to 19 years was 67·3 per cent. and in females 65·4 per cent., as compared with increases of 60·9 per cent. and 56·2 per cent. for males and females aged 20 to 24 years, and 33·5 and 18·0 per cent. for males and females of other age groups.

Other Venereal Diseases

New cases of chancroid continued to fall, from 231 in 1960 to 228 in 1961, again the lowest figure on record.

There were 98 cases of lymphogranuloma venereum, as compared with 102 in 1960, and fourteen cases of granuloma inguinale, as compared with the same number in 1960. Cases of non-gonococcal urethritis in the male increased from 22,004 in 1960 to 24,472 in 1961 (Appendix Table A). The number of such cases has increased each year since 1951, when they were first shown in a separate category and number reported was 10,794. In spite of much investigation the cause of this condition has not been isolated, and it seems unlikely that there will be sufficient progress in treatment to establish control until this has been achieved. Women suffering from this disease, or group of diseases, are usually identified by the evidence of infection in sexual partners, because the signs in female cases are not distinctive. For this reason, non-gonococcal genital infections in women are not shown in a separate category but appear as "other conditions requiring treatment". The number of female cases under this heading increased from 15,199 in 1960 to 16,861 in 1961.

Other Conditions Treated at the Clinics

These form a considerable part of the work of the clinics. The patients vary from those who require no more than reassurance, to those who require treatment for a variety of genital conditions which may or may not have been acquired sexually. All require detailed examination, tests, and sympathetic consideration of their problems. The existence of centres where patients who are worried and ashamed may seek advice and reassurance in conditions of secrecy and without necessarily troubling their own doctors, is regarded by them as a great asset and it is one of which they take full advantage. Table A of the Appendix shows that during 1961 there were 35,423 such cases in which active treatment was required and 39,689 in which advice and reassurance were sufficient. These figures compare with 32,592 and 36,963 for the same groups in 1960.

The Present Position

As yet there is no indication that the upward trend of the incidence of the main venereal diseases is losing momentum. Apart from wartime conditions,

the factors which lead to increase or diminution of the spread of venereal disease are usually complex and often obscure.

There is evidence that four groups of the population, immigrants, adolescents, prostitutes, and homosexuals, are making a considerable contribution but other factors are no doubt also concerned. London, as for many years, contributes much more than its share on a population basis, but this may be partly due to persons coming in from outside. Promiscuity is the root cause of the problem and this is a matter on which the medical services can exercise little or no control. On the medical side, the evidence indicates that the venereal disease service, in spite of staffing difficulties, is doing excellent work and serving the public well. Of course, there is room for improvement in any organization and the standards at the clinics and of the help they receive in epidemiological work from Medical Officers of Health are constantly under review by the authorities concerned. One of the problems to which attention has been drawn in certain peripheral areas is the difficulty which some patients have experienced in finding out the addresses of clinics and the times at which their services are available. This is a matter which local health authorities will wish to study in detail, in the light of local circumstances. The diligence of contact-tracing has seemed to vary from place to place and from clinic to clinic. It is seldom easy to persuade a bitter and disillusioned patient to seek out the source of infection and to persuade the sexual partner to attend a clinic. But many patients have a good sense of social responsibility and, if the matter is tactfully pursued, if necessary at visits after the first attendance, doctors and social workers may sometimes achieve striking success. There will always remain a number whose relationship was so casual and fleeting, or so clouded by alcohol, that the tracing of contacts is impossible. Much is to be gained by keeping the public informed about this matter, by posters, leaflets, and articles in newspapers, journals, and magazines. In this matter, the Central Council for Health Education continues to play an important part and the Press has been most co-operative. Recent television programmes have raised considerable public interest in medical problems and perhaps the time has come to consider whether the control of venereal disease would be assisted by further well-devised programmes devoted to this subject, on wireless and television.

APPENDIX

TABLE A

NUMBER OF CASES (IN ALL STAGES) DEALT WITH FOR THE FIRST TIME AT ANY CENTRE, 1950–61*

Sex	Year	Syphilis	Soft Chancre	Gonorrhoea	Non-Gonococcal Urethritis (Males only)	Other Conditions†		Total Sum of Columns 2–6
Male	1950	5,979	433	17,007	—	55,068		78,487
						Requiring Treatment	*Not Requiring Treatment*	
	1951	4,506	437	14,975	10,794	11,607	26,956	69,275
	1952	3,760	389	15,510	11,552	12,578	25,928	69,717
	1953	3,272	347	15,242	13,157	13,566	25,619	71,203
	1954	2,929	301	13,962	13,279	13,071	24,651	68,193
	1955	2,711	285	14,079	14,269	13,613	24,436	69,393
	1956	2,778	307	16,377	14,825	14,254	23,514	72,055
	1957	2,747	254	19,620	16,066	14,332	23,032	76,051
	1958	2,497	247	22,398	17,606	14,562	21,711	79,021
	1959	2,252	265	24,964	20,227	15,241	23,160	86,109
	1960	2,401	226	26,618	22,004	17,393	26,087	94,729
	1961	2,730	227	29,519	24,472	18,562	27,567	103,077
Female	1950	4,988	17	3,498	—	23,840		32,342
						Requiring Treatment	*Not Requiring Treatment*	
	1951	3,926	16	3,089	—	8,517	12,408	27,956
	1952	3,362	14	3,585	—	8,916	11,560	27,437
	1953	2,914	9	4,021	—	9,834	10,612	27,390
	1954	2,352	8	3,574	—	10,117	9,503	25,554
	1955	2,272	10	3,766	—	10,182	9,075	25,305
	1956	2 363	9	4,011	—	10,939	8,835	26,157
	1957	2,230	6	4,761	—	11,317	9,098	27,412
	1958	1,829	12	5,489	—	12,149	9,001	28,480
	1959	1,675	2	6,380	—	12,752	9,544	30,353
	1960	1,545	5	7,152	—	15,199	10,876	34,777
	1961	1,712	1	7,588	—	16,861	12,122	38,284

* Excludes cases transferred from centre to centre. † Including non-gonococcal urethritis up to 1950.

TABLE B

CASES OF ACQUIRED SYPHILIS IN TABLE A, WITH INFECTIONS OF LESS THAN ONE YEAR, 1950–61

Year	Number of Cases		Per cent. of Table A Cases	
	Male	Female	Male	Female
1950	2,678	1,465	44·8	29·4
1951	1,498	774	33·2	19·7
1952	891	462	23·7	13·7
1953	755	319	23·0	10·9
1954	600	208	20·5	8·9
1955	609	228	22·5	10·0
1956	587	257	21·1	10·8
1957	555	192	20·2	8·6
1958	522	182	20·9	9·9
1959	564	209	25·0	12·5
1960	819	175	34·1	11·3
1961	965	234	35·3	13·6

TABLE C

CASES OF CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME AT THE TREATMENT CENTRES, 1950–61

Year	Under 1 year	1 and under 5 years	5 and under 15 years	15 years and over	Totals
1950	227	141	203	652	1,223
1951	156	89	198	684	1,127
1952	110	101	191	547	949
1953	95	77	152	520	844
1954	48	41	119	478	686
1955	41	30	114	459	644
1956	36	31	82	441	590
1957	27	26	77	427	557
1958	17	15	65	340	437
1959	20	19	29	304	372
1960	18	10	38	323	389
1961	23	4	21	292	340

TABLE D

DEATH RATES PER 1,000 LIVE BIRTHS, OF INFANTS UNDER 1 YEAR CERTIFIED AS DUE TO CONGENITAL SYPHILIS, 1912–61

Year	Rate	Year	Rate	Year	Rate	Year	Rate
1912	1·34	1924	0·91	1936	0·24	1949	0·08
1913	1·46	1925	0·82	1937	0·19	1950*	0·04
1914	1·55	1926	0·84	1938	0·18	1951*	0·03
1915	1·44	1927	0·77	1939	0·17	1952*	0·03
1916	1·57	1928	0·71	1940	0·16	1953*	0·01
1917	2·03	1929	0·64	1941	0·21	1954*	0·003
1918	1·90	1930	0·55	1942	0·19	1955*	—
1919	1·76	1931	0·45	1943	0·23	1956*	—
1920	1·51	1932	0·42	1944	0·16	1957*	—
1921	1·43	1933	0·35	1945	0·15	1958*	0·004
1922	1·12	1934	0·30	1946	0·15	1959*	0·003
1923	1·05	1935	0·26	1947	0·09	1960*	—
				1948	0·09	1961	—

Rates for years 1931–49 are according to the 1940 classification (5th Revision). For 1912–30 the rates need to be multiplied by the conversion ratio 0·857 for approximate comparability.

* For 1950–61 No. 020·2 in International List (7th Revision).

TABLE E

DEATHS FROM GENERAL PARALYSIS OF THE INSANE, TABES DORSALIS AND ANEURYSM OF AORTA, 1911–61

Year	General Paralysis of the Insane		Tabes Dorsalis		Aneurysm of Aorta*	
	Male	Female	Male	Female	Male	Female
1911–20	1,697	383	592	106	838	208
1921–30	1,204	277	631	127	860	249
1931–35	819	240	566	125	969	393
1936–39	625	227	471	106	1,017	531
1940–44	482	167	270	71	367	124
1945–49	258	101	157	41	381	130
1950–54	98	42	93	27	336	166
1955	84	36	53	24	332	173
1956	56	28	66	15	329	171
1957	48	20	53	22	358	183
1958	57	28	41	16	307	219
1959	62	27	50	22	295	190
1960	56	22	44	17	312	186
1961	37	17	41	19	286	194

The averages for the years 1911 to 1939 are based on the 4th Revision of the International List. Figures for the years 1940 to 1961 are according to the 7th Revision.

Non-civilian deaths are excluded from September 3, 1939, for males and from June 1, 1941, for females to December 31, 1949.

* For years 1911–1939:
"Aneurysm" (code 96) of the 4th Revision List based on arbitrary rules of assignment.
For years 1940 and after:
"Aneurysm of Aorta" (code 022) of the 7th Revision List based on assignment by the certifying medical practitioner.